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Department of Health and Hospitals
Office for Citizens with Developmental Disabilities

ACT 299
Administrative Burden Committee Report

Background

The Administrative Burden Committee is one of several subcommittees formed pursuant to ACT 299 of the Legislative session of 2011as part of DHH's comprehensive plan regarding the quality of services provided to individuals receiving Home and Community Based Services (HCBS). Billing issues have been a main concern for providers, and there has been a group working on this to address ways in which this process could be less burdensome. These recommendations are addressed below.

GOAL

The goal of this committee is to look at the administrative burdens of providers in the HCBS programs, look at what areas may be streamlined, other areas that are duplicative and outdated, and to make recommendations and solutions for improvement.

STRATEGY AND RECOMMENDATIONS

A stakeholder group was convened on October 24th, 2011 to address the administrative burdens that providers are currently experiencing in the HCBS programs. Prior to this meeting, there had been a stakeholder group addressing billing/LAST issues, and this appears to be a major burden to a large number of providers.

The following are recommendations for changes to the LAST program that will be implemented on October 25th, 2011:

A. Changes to data entry form (OCDD and OAAS data entry screens).
   1. Allow the agency the choice of entering dates in dd/mm/yy format or continue with American format(mm/dd/yy) to reduce the amount of required typing for date entry.
   2. Do not automatically roll over to next date on new data entry line. Hold prior date of service for new line until changed by user.
   3. Duplicate the line if a shared supports procedure code is entered.

4. Look at the "hickey" spaces problem-force cursor to the beginning of a blank box, if possible.
5. While the committee has identified some input and report generating types of efficiencies that can be implemented in the short term use of the LAS program, the concern for administrative burden with billing remains. A change in the structure of the entire billing process is needed, one that is call-based and is or could be made to be compatible with existing call-in payroll and accounting systems that providers are currently using.

B. Reports
1. Add a report to show just the individuals whose PA's have been exceeded.
2. If PA's have been exceeded, modify Service Summary Report to show by how much
3. Modify Service Summary Report to show weekly caps if the PA has a weekly cap (typically OAAS services).
4. Add a Children's Choice waiver report to show budget amount, amount used, and amount remaining (by 12/1/2011).
5. Add totals to the Service Event List (12/1/2011).
6. Modify Service Summary Report to show daily totals if multiple lines are listed for a procedure code for a day (requires further discussion).
7. Add a report showing typical schedule (hours per day)/actual hours per day/deviations from typical schedule (requires further discussion).

C. Other Changes
1. Check overlaps with Day Hab and IFS services (11/1/2011)
2. Add user define fields for use by agency (e.g., some agencies wanted variables to track "Fund" and "Supervisor".
3. Modify the report from SRI to Children's Choice waiver recipients to show an "as of" date, their balance will be less (implemented 11/1/2011.
4. Develop and auto mated to "reset services that previously had insufficient units but now have sufficient units due to PA or CPOC revision. (Currently the user must manually find, edit, and save these records). (10/01/2011)
5. Look at the possibility of exporting reports to Excel (requires further discussion).

A number of providers have requested about the ability to import data into the LAST system, stating this would allow the process to go much faster. This is not allowed at this time. Paul Rhorer will meet individuals from Waiver Assistance and Compliance to discuss this by 12/012011.

Audits

Provider agencies were extremely upset about the recent P & N audits. Most felt that it was a hardship and burden for them, and they were not given the requirements of the audit beforehand, as many were cited for areas they had never been cited before. Listed below are comments from providers concerning the audits:

1. There was no "pre-audit" meeting to discuss what exactly would be needed or to explain the information requested;
2. Inconsistencies amongst providers; some providers had exit interviews while others did not;
3. Providers could not determine how monetary figures were accounted for in the audit findings. Providers were fined for areas that typically had been educational/training issues from other audits.
4. Providers would like a protocol or a plan for the next round of audits. They want audits, but they want to know what to expect and a clear explanation of what is required and what will they be fined for and a monetary amount for each fine.
5. How are selections made for the audits?
6. SURS audits-providers are sent recoupment letters stating that they owe money due to the billing while the individual was in the hospital; providers have to spend an enormous amount of time gathering time sheets, progress notes, etc to prove that they did not bill during hospital time. Providers say the burden of proof regarding hospital admit time needs to be on the hospital. They referenced their responsibility to remain with the client to assist them until a caregiver arrives or the hospital admits them as a patient. They complained that they are continually denied payments because the hospital fails to enter the correct time, or they don't report it on the correct form and/or file.

   These audits appeared to be a significant burden on the providers who went through them. Providers realize audits need to occur, they just want to be aware of what they will be responsible for. Internal discussion between program offices and Program Integrity to discuss future audits.

CPOC's/PA's (primarily OCDD)

1. Providers complain about not getting copies of CPOC's/Revisions in a timely manner
2. Providers are not getting PA's timely
3. CPOC's/revision changed without provider notification
4. Providers not being invited to the SIS/LaPlus, family members not being able to obtain a copy of the SIS.

   Provider agencies complain about having to track down CPOC's, PA's, and revisions, which waste a lot of time, and also results in incomplete documentation when they are audited. The implementation of the Electronic Plan of Care should take care of the above concerns.

   In the interim, Paul Rhorer and Teresa Frank will address with SC agencies and provider representatives of the above problems by 1/31/2012.

INFORMATION

It would be nice to have a web site where providers could access information concerning the waivers, where all manuals, updates, etc is easily viewed and they would all be in one place.

This committee will continue to meet to address these concerns and to offer solutions how they can be addressed.

DELIVERABLES/TIMELINES

-all changes agreed by the committee to LAST to be implemented by 12/1/2011

-committee will address changes requiring further discussion (LAST program) and make a decision by 1/31/2012

-an audit stakeholder group is being formed by Program Integrity to address the above issues in concerns of the audits

-meeting to be held to address electronic visit verification (call based billing) and how it will work; how providers who already are doing call based timesheets will be incorporated into the new system, costs, etc. 1st meeting to be held in November 2011, and will be internally with DHH staff

-CPOC/PA issues to be addressed by 1/2012 with the Support Coordination Alliance.